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I. BACKGROUND AND JURISDICTIONAL STATEMENT

This appeal arises from a damage action brought against Dr. Debra Howenstine for medical negligence. Howenstine has been sued because of her actions and failures to act as a licensed physician, practicing medicine at the Columbia/Boone County Health Department ("CBCHD") clinic, based upon her entry, as a physician, into collaborative practice arrangements with registered nurses, pursuant to 4 C.S.R. 200-4.200(3)(B) of the Code of State Regulations of Missouri. Through collaborative practice agreements, Howenstine delegated authority to registered nurses to perform medical acts in her stead, including dispensing anti-tuberculosis drugs and diagnosing adverse reactions to such drugs. Howenstine failed to "ensure" that the nurses had the required "skill, training, education, and competence" to diagnose adverse drug reactions and determine the propriety of dispensing further drugs pursuant to the Missouri Department of Health Tuberculosis Control Manual. As a result, Paul Muren was systematically dispensed and instructed by nurses to continue taking the anti-tuberculosis drug INH, after he demonstrated adverse reactions to the drug. Between April and September of 2000, the INH drug poisoned and destroyed Paul's liver. In September of 2000 Paul Muren was evacuated to St. Louis by life-flight helicopter where he underwent liver transplantation.

Relator seeks review of past rulings made by Respondent, Ellen S. Roper, Circuit Judge of Division 3 of the Circuit Court of Boone County, Missouri. By order issued April 6, 2004, Judge Roper denied Howenstine's Motion for Summary Judgment, premised upon the affirmative defenses of "official immunity" and the "public duty doctrine."

Thereafter, Howenstine sought, and, by order dated May 10, 2004, was denied a Writ of Prohibition in the Missouri Court of Appeals, Western District. This appeal followed. Jurisdiction in this proceeding is premised upon this Court's constitutional authority to issue and determine original remedial writs pursuant to Article V, Section IV of the Missouri Constitution.

II. ISSUES ENCOMPASSED BY THIS APPEAL

On behalf of Respondent, the Murens respectfully submit to the Court that the following legal issues are framed by this appeal:

(1) Whether a licensed Missouri physician who enters into a collaborative practice arrangement with a registered nurse, pursuant to 4 C.S.R. 200-4.200(3)(B) et seq., which enables the nurse to undertake medical acts in her stead, can be held liable for damages which result from the physician's failure to "ensure" that such registered nurse has the requisite skill, training, education, and competence to perform the delegated responsibilities as required by 4 C.S.R. 200-4.200(3)(A)(B) and (I);

(2) Whether a licensed Missouri physician who enters into a collaborative practice arrangement with a registered nurse in a public clinic, which enables the nurse to undertake medical acts in her stead, can be held liable for damages which result from the physician's failure to "ensure" that such nurse has the requisite skill, training, education, and competence to perform the delegated responsibilities as required by 4 C.S.R. 200-4.200(3)(A)(B) and (I);

(3) Whether Relator, Debra Howenstine, M.D., a licensed Missouri physician, is a "public official" under Missouri law and the facts of this case;

(4) Whether Relator, Debra Howenstine, M.D.'s, entry into collaborative practice arrangements with registered nurses at CBCHD represents an "exercise of the sovereign power" of the state of Missouri, Boone County, or the City of Columbia, warranting the protection of "official immunity" from her negligent acts;

(5) Whether a licensed Missouri physician who enters into a collaborative practice arrangement with a registered nurse in a public clinic, which collaborative practice arrangement relates to the delivery of tuberculosis care, is deemed to be discharging a "public duty;"

III. STATEMENT OF FACTS

A. About Dr. Howenstine

At all times relevant to this action, Relator, Debra Howenstine, M.D., was a physician licensed to practice medicine by the state of Missouri. (Relator's Ex. 9 at pp. 056-058.) At all times relevant to these proceedings, Howenstine was exclusively employed by the University of Missouri-Columbia, as an Assistant Professor of Clinical Family and Community Medicine. (Id. at p. 056.) All aspects of Howenstine's employment were controlled exclusively by the Curators of the University of Missouri. (Id. at p. 012.) The University of Missouri was Howenstine's sole source of pay. (Id.)

By written agreement between the University of Missouri and the City of Columbia, the university agreed to provide certain enumerated "Physician Services" to the CBCHD. (Id. at p. 003.) Howenstine was designated by her employer, the University of Missouri, to

perform the enumerated Physician Services at the CBCHD on the University's behalf. As a result, Howenstine's services as a physician were "subcontracted" by the University to the CBCHD. (Id. at p. 006.)

Howenstine is not and never has been an employee of the state of Missouri, the Missouri Department of Health, Boone County, the City of Columbia or the CBCHD. (Id. at pp. 026, 056-058.) Howenstine is not an elected official. (Id. at 056-058.) Howenstine had no official job description at the CBCHD. (Id. at p. 007.) Neither Howenstine, nor the job title she was given at the CBCHD was listed in the organizational chart of the City of Columbia Health Department. (Id. at p. 019; Appendix to Relator's Brief, Ex. 5, p. A47.)

During the year 2000, when Paul Muren was receiving treatment, Howenstine was a part-time doctor. She worked 80% of a full-time position for the University of Missouri. (Id. at p. 009.) That equates to 40 to 45 hours per week. (Id.) Approximately 60% of her time (30 hours per week) was given over to the CBCHD pursuant to the Agreement for Services with the University of Missouri. (Id.) The balance of her time was spent teaching, lecturing and seeing patients in practice at the Green Meadows Clinic. (Id. at pp. 009-010.)

B. The Agreement for Services

Howenstine's "duties" at the CBCHD were enumerated in the contract between the University of Missouri and the City of Columbia. (Relator's Ex. 9 at p. 028.) The "Agreement for Services" between the University and the City of Columbia required the University, through Howenstine, to perform the following physician services:

(a) Provision of primary care medical services for patients of the Columbia/Boone County Health Department;

(b) Consultation and oversight of advance practice nurses;

(c) Maintenance of collaborative practice agreements with advance practice nurses employed by the Columbia/Boone County Health Department;

(d) Oversight of medical practice of family medicine resident physicians in their public health rotation; and

(e) Maintain collaborative practice agreements (as dictated by expanded practice) with registered nurses employed by the Columbia/Boone County Health Department.

(Id. at p. 003.) Among the physician services enumerated above, it is item (e), Howenstine's entry into collaborative practice arrangements, to expand her medical practice, that spawned this suit against her. The contract for physician services further provided that Howenstine's services could be terminated upon sixty (60) days notice and, subject to appropriation of funds each year, the city had the right to renew the contract for four (4) additional one (1) year periods. (Id.)

C. The Missouri Collaborative Practice Act

In 1996, by regulation, Missouri adopted the Collaborative Practice Act. (Relator's Ex. 9 at p. 008.) Deposition Exhibit 30, marked in the underlying action, is a copy of 4 C.S.R. 200-4.200, et seq. – the Missouri Collaborative Practice Act. (Id. at pp. 029-031.) Beginning in 1996, by entering into a collaborative practice arrangement, a physician could expand his/her medical practice by delegating the ability to perform enumerated medical acts to registered nurses. The dispensing of drugs and diagnosing of adverse drug reactions

are examples of medical acts nurses are unable to perform absent a collaborative practice arrangement. (See, Appendix to Relator's Brief, Ex. 4, p. A46.)

4 C.S.R. 200-4.200(3)(A) and (B) set forth legal duties which doctors and nurses who enter into collaborative practice arrangements must follow. (Relator's Ex. 9, pp. 029-031.) 4 C.S.R. 200-4.200(3)(A) and (B) mandate that doctors who enter into collaborative practice arrangements with registered professional nurses must "ensure" that the registered nurses with whom they collaborate have the requisite "… education, training, skill and competence" to perform the delegated acts. (Id. at pp. 029-031.)

D. Howenstine's "Expanded Practice" – Use of Collaborative Practice Arrangements

Following adoption of the Collaborative Practice Act, the CBCHD began utilizing collaborative practice arrangements for the delivery of tuberculosis healthcare in the clinic. (Relator's Ex. 9 at p. 062.)

Howenstine's agreement to "maintain collaborative practice arrangements (as dictated by expanded practice)" was put into effect. (Id. at p. 004, Section II E.) Howenstine entered into collaborative practice arrangements with the registered nurses at the CBCHD, permitting the nurses to undertake every aspect of medical care for tuberculosis patients at the clinic, including Paul Muren. (Id. at pp. 015-016.) The collaborative practice arrangement between Howenstine and the CBCHD registered nurses regarding tuberculosis is reflected by Deposition Exhibit 4. (Id. at pp. 039-041.) The written protocol the nurses were to use for tuberculosis care is contained in Deposition Exhibit 4, p. L-46. (Id. at p. 042.) Included among the many medical acts which

Howenstine delegated to the CBCHD nurses, was the ability to dispense tuberculosis medication, and diagnose adverse reactions to such drugs. Id.

In the present case, every aspect of the tuberculosis care which Paul Muren received at CBCHD was provided to him by nurses, as a result of Howenstine's grant of authority and her expanded practice through collaborative practice arrangements. (Id. at pp. 059-093.)

E. 4 C.S.R. 200-4.200(3)(A)(B) and (I) apply to Howenstine and her collaborative practice arrangements with CBCHD nurses

In her recitation of facts, Relator suggests that the provisions of 4 C.S.R. 200-4.200(3)(A)(B) and (I) and the requirement that the doctor 'ensure" the skill, education, training or competence of the collaborating nurses do not apply to Dr. Howenstine and her collaborative practice arrangement with the CBCHD nurses. As authority, Relator cites a provision contained in the Public Health Nursing Manual. However, the Public Health Nursing Manual is not law. Further, Relator has secured the services of and employed Dr. Colleen Kivlahan as an expert witness for the defense in the present case. Dr. Kivlahan was the Director of the Missouri Department of Health from 1993 through 1997, including the time when the Missouri Collaborative Practice Regulations were adopted. As a part of her job, Dr. Kivlahan approved all of the standards promulgated by the state, including those dealing with tuberculosis. (See, Exhibits to Answer to Petition for Writ of Prohibition, Ex. D, Deposition of Colleen Kivlahan, pp. 048-050.) Regarding the application of 4 C.S.R. 200-4.200(3)(A)(B) and (I) to this case, Dr. Kivlahan testified unequivocally that all such sections apply to Dr. Howenstine's collaborative practice arrangements with the CBCHD

nurses and to the delivery of tuberculosis services at the CBCHD. (See, Relator's Ex. 9, pp. 035-036.)

F. Plaintiffs' claims against Howenstine

As stated above, the Missouri Collaborative Practice Act, 4 C.S.R. 200-4.200(3)(B), requires every physician that enters into a collaborative practice arrangement with a registered nurse to "ensure" that the collaborating nurse has the "skill, education, training and competence" to discharge the delegated responsibilities. By delegating the methods of treatment for tuberculosis control to the registered nurses at CBCHD, it was Howenstine's duty as the collaborating physician, to "ensure" that the nurses whom she enabled and placed in a position to see patients in her stead, had the requisite education, training, skill and competence to provide tuberculosis treatment in conformity with the Missouri Department of Health Tuberculosis Control Manual and the CDC Core Curriculum on Tuberculosis. Count I of Plaintiffs' Second Amended Petition avers that, as required by the Missouri Collaborative Practice Regulations, Howenstine, as a collaborating physician, owed a duty to individuals whom would receive treatment from registered nurses acting pursuant to her collaborative practice authorization, to "ensure" that such nurses had the requisite level of education, training, skill and competence to deliver the delegated responsibilities. (See, Exhibits to Answer to Petition for Writ of Prohibition, Ex. A, Second Amended Petition for Damages, paragraph 56(B), p. 012.)

Plaintiffs' claims against Howenstine arise from the medical actions and decision-making she undertook as a collaborating physician in entering into collaborative practice agreements. Plaintiffs' claims are premised upon the failure by Dr. Howenstine to

discharge her duties to those who received tuberculosis treatment from her collaborating nurses. In this case, the nurses to whom she delegated medical responsibility lacked sufficient education, training, skill and competence to follow the requirements of the Missouri Department of Health Tuberculosis Control Manual and the CDC Core Curriculum on Tuberculosis. Specifically, the nurses continued to dispense the drug INH to Paul Muren and instructed him to continue taking it even though he had demonstrated symptoms of an adverse reaction to the drug. The Muren claims arise solely from medical decision-making – medical acts delegated by Howenstine as a result of negligently entering into collaborative practice arrangements - with nurses who were untrained and lacked the skill and competence to follow the prescribed standard of care, reflected by the Missouri Department of Health Tuberculosis Control Manual. Plaintiffs have not sued Howenstine for administrative or policy-making activity. Rather, Plaintiffs have sued her for her negligence in expanding her medical practice by delegating medical authority to registered nurses without ensuring their competence to undertake the delegated responsibility.

G. The duty to ensure the skill, education, training and competence of the CBCHD tuberculosis nurses

Having entered into collaborative practice arrangements with the nurses, delegating to them the ability and responsibility to perform medical acts in her stead, the Missouri Collaborative Practice Act required Dr. Howenstine to "ensure" that the "delegated responsibilities" were within the skill sets, training, education and professional competence of the nurses. Conversely, if the nurses lacked adequate training, skill sets, education and competence to provide tuberculosis care within the requisite standard of care, then Dr.

Howenstine was obligated to refrain from entering into collaborative practice arrangements. Throughout this litigation, Howenstine and her attorney have denied that it is her responsibility to ensure appropriate skill, training, education and professional competence. (See, Petition for Writ of Prohibition, ¶ 20; see also, Relator's Brief, p. 42.) Therein lies the problem. 4 C.S.R. 200-4.200(3)(A) and (B) say it was her job. Mary Martin, Public Health Manager for the City of Columbia Health Department, has also testified that Dr. Howenstine shared responsibility for training and supervision of the public health nurses in the clinic. (Relator's Ex. 9 at pp. 021, 024.) Moreover, the nurses that provided health care to Paul Muren, including Stephanie Potter, Kena McAfee, Aleta Miller and Carolyn Davidson, uniformly say that they worked under the supervision of Dr. Howenstine, among others, in providing tuberculosis care. (See, e.g., Exhibits to Answer to Petition for Writ of Prohibition, Ex. B, p. 039; Ex. C, pp. 041-046.)

The Collaborative Practice Act itself provides for individual physician liability in connection with entry into collaborative practice where, as here, there is a delegation of methods of treatment and authority to dispense drugs. In addressing the "methods of treatment delegated" 4 C.S.R. 200-4.200(3)(I) states:

> 1. The physician retains the responsibility for the appropriate administering, dispensing, prescribing and control of drugs utilized pursuant to a collaborative practice arrangement . . .

Further, when the Missouri Department of Health implemented the Collaborative Practice Act, pursuant to its rule making authority in 1996, it expressly addressed the issue

of the physician's liability for collaborative practice arrangements in the comments contained within the Missouri register. There, the following statements appear:

> COMMENT: Within the Methods of Treatment section, one letter of comment addressed paragraph (3)(I)1. with the concern that no physician will want to enter into a collaborative practice arrangement that includes the specified provision of responsibility and accountability related to drugs.
>
> **RESPONSE: The boards identified that the decision to enter into a collaborative practice arrangement is voluntary and, <u>whether stated or not, delegated medical acts carry with them physician responsibility to provide suitable oversight to validate having made appropriate delegative decisions</u>. Accountability and responsibility for their own actions are also retained by advanced practice nurses and registered professional nurses who are not advanced practice nurses. Based on the nature of the public comments, the boards made no language changes to the Proposed Rule.** *See*, <u>Order of Rulemaking</u>, Volume 21, Mo. Register, No. 15, August 1, 1996, p. 1794. (emphasis supplied) (Relator's Ex. 15 at p. 023.)

Conspicuously, neither the Collaborative Practice Act nor the rule-making comments of the Missouri Department of Health make exception to liability for a doctor, such as Howenstine, practicing in a public clinic.

H. Examples of Howenstine's failure to "ensure" the CBCHD nurses possessed the skill, education, training and competence to provide tuberculosis care in conformity with the Missouri Department of Health Tuberculosis Control Manual

Nurse Aleta Miller saw Paul Muren on May 23, 2000. (Relator's Ex. 9 at p. 094.) On that date, Miller made note in the CBCHD records that Paul Muren was demonstrating an adverse reaction to the drug INH. (Id.) The Missouri Tuberculosis Control Manual instructed nurses that "if symptoms are mild, continue drug and submit blood for liver profile. If more severe or if tea colored urine or jaundice is present, discontinue drug until consultation with physician; submit blood for liver profile." (Exhibits to Answer to Petition for Writ of Prohibition, Ex. E, p. 052.) Despite Paul's documented adverse reaction, Aleta Miller did not submit Paul Muren's blood for liver profile. (Relator's Ex. 9 at pp. 061, 094.) Aleta Miller did not know the CBCHD policy regarding when INH should be discontinued. (Id. at p. 046.) As of May 23, 2000, Miller believed that it was no longer necessary to draw blood to conduct liver function tests on INH patients who reported an adverse effect to INH. (Id. at pp. 044-045.)

Nurse Carolyn Davidson saw Paul Muren on July 26, 2000. (Id. at p. 094.) On that date Davidson noted in the CBCHD records that Paul Muren was demonstrating a symptom of an adverse reaction to the drug INH. (Id.) Nurse Davidson had received no instruction or directives from her collaborating physician, Dr. Howenstine, regarding when Howenstine was to be consulted regarding INH patients who expressed and adverse reaction to the drug. (Id. at p. 052.) In July of 2000, nurse Davidson did not know what the Missouri Department

of Health Tuberculosis Control Manual required a nurse to do in a situation where an INH patient complained of being tired or fatigued. (Id. at p. 049.) Nurse Davidson was aware of no policy in existence at the CBCHD from April through September of 2000 that told nurses what to do in the event a tuberculosis patient receiving INH reported one or more symptoms of an adverse reaction to the drug. (Id. at p. 048.)

Nurse Kena McAfee saw Paul Muren at the CBCHD clinic on August 23, 2000. (Id. at p. 094.) On that date McAfee noted in the CBCHD records that Paul Muren was demonstrating multiple symptoms of an adverse reaction to INH. Specifically, she recorded that he was fatigued and that he had experienced a change in the color of his urine. (Id.) Nurse McAfee had never received any formal training or education from Dr. Howenstine or anyone else at the CBCHD regarding the potential side-effects of INH. (Id. at pp. 054-055.) Again, no liver function tests were ordered. (Id. at pp. 061, 094.)

I. Plaintiffs' expert testimony regarding Howenstine's deviation from the standard of care

Dr. Shelley Salpeter, a member of the standing committee of the Center for Disease Control that wrote the United States standard for tuberculosis treatment has testified that Dr. Howenstine was negligent in failing to provide proper supervision and training of the health department nurses. More specifically, she testified that Dr. Howenstine "failed in her duty to adequately supervise and ensure training of her nurses and nurse practitioners in her clinic." (Relator's Ex. 9 at p. 096.) She further testified that by delegating the authority to provide tuberculosis control services and based upon the Missouri Collaborative Practice

Act, Howenstine had a duty to "ensure" that the delegated acts were within the skill, training, education and competence of the nurses involved. (Id. at pp. 098-099.)

IV. THE PROPRIETY OF PROHIBITION UNDER THE FACTS OF THIS CASE

Generally, "prohibition is a means of restraint on judicial personnel to prevent usurpation of judicial power, and its essential function it so confine inferior courts to their proper jurisdiction and to prevent them from acting without or in excess of their jurisdiction." See, e.g. State ex rel. Hamilton v. Dalton, 652 S.W.2d 237 (Mo. App. E.D. 1983). Missouri courts recognize that "a writ of prohibition is a proper remedy where a judge, with jurisdiction of the subject matter and the parties, threatens to act or proceed in a manner so in excess of jurisdiction possessed that he may be said to be acting without jurisdiction." State ex rel. Albert v. Adams, 540 S.W.2d 26, 31 (Mo. banc 1976). The writ issues to restrain the commission of a future act and not to undo one that has already been committed. State ex rel. Ellis v. Creach, 364 Mo. 92, 259 S.W.2d 372, 375 (Mo. banc 1953). The Realtor has the burden to establish that the Respondent Judge will usurp or act in excess of his jurisdiction in overruling her motion for summary judgment. State ex rel. Tarrasch v. Crow, 622 S.W.2d 928, 937 (Mo. banc 1981).

The appellate courts of Missouri have often stated that "prohibition is an extraordinary writ and is not to be used as a substitute for appeal." State ex rel. Spear v. Grimm, 599 S.W.2d 67, 69 (citations omitted)(Mo. App. E.D. 1980). Prohibition is ordinarily not used to review summary judgment rulings in the lower courts. The rationale is straightforward enough. An order denying a summary judgment motion is interlocutory

and neither final nor appealable. See, e.g. State ex rel. Spear v. Grimm, 599 S.W.2d 67, 69 (citations omitted)(Mo. App. E.D. 1980). It is not *res judicata*. Id. Moreover, it is subject to later and further review by the trial court and if good reason is shown why the prior ruling is no longer applicable or for some other reason should be departed from, the court can entertain a renewed motion for summary judgment in the interest of effective judicial administration. Id. at 69.

Prohibition is not a substitute for direct appeal and cannot be used to undo erroneous judicial proceedings. State ex rel. Douglas Toyota III, Inc. v. Keeter, 804 S.W.2d 750, 752 (Mo. banc 1991). An exception to these holdings has been fashioned.

This court has stated "though prohibition is generally unavailable if an appeal would provide adequate relief, this court has recognized that a writ of prohibition after the denial of summary judgment is proper if it will prevent unnecessary, inconvenient or expensive litigation." State ex rel. Springfield Underground, Inc. v. Sweeney, 102 S.W.3d 7, 8-9 (Mo. banc 2003)(citations omitted). The cases in which a writ of prohibition has been employed to review a summary judgment ruling have been limited to cases which generally demonstrate, on the face of the pleadings, themselves, that a claim is barred or should not go forward.

For example, in State ex rel. Hamilton v. Dalton, the Eastern District of the Missouri Court of Appeals considered and issued a writ of prohibition prohibiting a second lawsuit which duplicated an earlier one that had been dismissed with prejudice. The father and next friend of James A. Mussman, a minor, sued Mary Lou Hamilton, his school teacher, and others for damages in 1971. The case was ultimately dismissed with prejudice. After James

Mussman became an adult, he again sued Mary Lou Hamilton for the same personal injuries. Defendant sought summary judgment premised upon principles of *res judicata*. Noting that it was "…unnecessary to resort to any evidence *dehors* the pleadings to determine that there are no material issues of fact or law remaining and that plaintiff's cause of action is barred by the doctrine of *res judicata*," the court issued its preliminary and absolute writ of prohibition.

Similarly, State ex rel. Sisters of St. Mary v. Campbell, 511 S.W.2d 141 (Mo. App. E.D. 1974), plaintiff sued a hospital for medical malpractice in connection with the death of a child. Because the statute of limitations for tort claims (two years) had run, plaintiff cast his action as wrongful death based upon breach of contract, governed by a five year limitation period. In issuing its permanent writ of prohibition, the court recognized that claims for malpractice, whether denominated as "tort" or "breach of contract" were subject to a two year statute of limitations. Succinctly, it was apparent on the face of the pleadings that the statute of limitations had run. The underlying litigation would therefore have been wasteful. Prohibition issued.

Such is not the case in the current action. Under the facts of the present case, it cannot reasonably be said that it is apparent, on the face of the pleadings, that Plaintiffs' claims should not go forward. There is no demonstration of a statute of limitations defense; no demonstration of a lack of jurisdiction; and no demonstration of Howenstine's obvious status as a "public official." Instead, the facts are substantially in dispute regarding her status as a public official; whether the acts which form the basis of Plaintiffs' claims against her are "discretionary" within the legal definition of the phrase; and certainly whether or not

Howenstine has complied with her duty to "ensure" that her collaborating nurses possessed the requisite skill, education, training and competence, to provide medical care to tuberculosis patients in conformity with the Missouri Department of Health Tuberculosis Control Manual and CDC Core Curriculum on Tuberculosis. Counsel for the Murens respectfully submit that this Court should refrain from making the Writ of Prohibition permanent under the circumstances at hand.

V. ARGUMENT

A. Relator is not immune from liability based on the Doctrine of Official Immunity for the reason that (1) Relator, as a licensed Missouri physician, practicing in a public clinic, is not a public official; and (2) Relator's conduct which gave rise to Plaintiffs' claims is not "discretionary" within the legal definition and does not involve "exercise of the sovereign's power" which goes to the essence of governing

The Missouri Doctrine of Official Immunity

In Missouri the doctrine of official immunity has been adopted to protect "public officials" from tort liability in connection with the actions they have taken conducting the public's business. See, e.g. Kanagawa v. State by and through Freeman, 685 S.W.2d 831 (Mo. banc 1985). The doctrine derives from society's compelling interest in the "vigorous and effective administration of public affairs." Id. at 836. In the application of the doctrine, Missouri's courts have sought to distinguish those actions taken by public officials which are protected, from those which are not, by attempting to classify the acts as either ministerial or discretionary. Ministerial duties are those which are of a clerical nature, performed in obedience to a mandate, without the exercise of judgment on the part of the official. See, e.g. Jackson v. Wilson, 581 S.W.2d 39, 43 (Mo. App. 1979). Ministerial acts receive no protection under the doctrine of official immunity. Discretionary acts, on the other hand, are those "necessarily requiring the exercise of reason in the adoption of means

to an end, and discretion in determining how or whether an act should be done or a course pursued." Jackson v. Wilson, supra at 43.

However, not all discretionary acts are protected. Instead, the courts have recognized that, "The discretionary decisions, the protection of which is the purpose of the doctrine of official immunity, are those which are a manifest exercise of the sovereign's power those decisions which 'go to the essence of governing'." (citations omitted) State ex rel. Eli Lilly & Co. v. Gaertner, 619 S.W.2d 761, 765 (Mo. App. E.D. 1981). Missouri courts have thus declined to extend immunity to all "discretionary" acts. As the court in Gaertner expressly stated, "Shielding officials for decisions other than those made in the exercise of the sovereign's power which go to the essence of governing, extends the doctrine of official immunity beyond its original intent to promote smooth and effective government." Id. at 765 (emphasis supplied). In Cooper v. Bowers, 706 S.W.2d 542 (Mo. App. W.D. 1986), the court stated that "… acts not within the area of conduct partaking of the 'essence of governing' do not qualify for official immunity regardless of whether they be ministerial or discretionary." Id. at 543. The Missouri test, therefore, is to determine whether or not the conduct which gives rise to the cause of action is ministerial or discretionary. If deemed discretionary, the analysis must further be made as to whether or not the discretionary conduct involves the "essence of governing" in order for official immunity to attach.

In the instant case, Plaintiffs' claims are predicated upon the failure to order liver function tests following Paul Muren's demonstration of symptoms of an adverse reaction to the drug INH, as required by the Missouri Department of Health Tuberculosis Control

Manual. The negligent conduct is that of Dr. Howenstine, having delegated responsibility for diagnosis of adverse drug reactions and the ability to dispense drugs in her stead, without first ensuring that her collaborating nurses possessed the requisite skill, education, training and competence to do so in compliance with the standard of care. Clearly, the negligent failure to diagnose Paul Muren's adverse reaction to INH; the failure to follow the Missouri Department of Health guidelines regarding ordering liver function tests; and the negligent dispensing of INH following ongoing adverse drug reactions do not involve the "essence of governing" in any sense. The principal question before this Court is whether or not Howenstine's entry into the collaborative practice arrangements, thereby expanding her medical practice by placing unqualified nurses in Howenstine's position with patients, constitutes an action demonstrating the "essence of governing."

1. Howenstine is not a public official – there are disputed material facts regarding this issue

The analysis in this case first begins with the identification of who is a "public official." The Missouri cases addressing the question have recognized that "a public office is the right, authority and duty created and conferred by law, by which for a given period, either fixed by law or enduring at the pleasure of the creating power, an individual is vested with some portion of the sovereign functions of the government to be exercised by him for the benefit of the public. The individual so invested is a public officer." State ex rel. Pickett v. Truman, 64 S.W.2d 105, 106 (Mo. banc 1933)(citations omitted).

Scobee v. Meriweather, 200 S.W.2d 340 (Mo. banc 1947), considered the question of whether or not a person is a public officer. The court's analysis resulted in the

enumeration of four criteria to consider, including (1) the giving of a bond for faithful performance of the service required, (2) definite duties imposed by law involving the exercise of some portion of the sovereign power, (3) the continuing and permanent nature of the duties enjoined, and (4) the right of successor to the powers, duties and emoluments.

In Kirby, et al. v. Nolte, 164 S.W.2d 1 (Mo. banc 1942), this court adopted a definition of a public officer. There, it was stated, "courts and text writers agree that a delegation of some part of the sovereign power is an important matter to be considered. . . . [and] such power must be substantial and independently exercised with some continuity and without control of a superior power other than the law." Kirby, et al. v. Nolte, at 8. (citations omitted)

By the criteria enumerated above, Dr. Howenstine is clearly not a public official. She is not elected to her office as a physician at the CBCHD. She is not an employee of the state of Missouri, the Missouri Department of Health, Boone County, or the City of Columbia. She is not even an employee of the CBCHD, the entity through which she claims her status as a "public official." Instead, her presence at the CBCHD is and always has been controlled exclusively by the Curators of the University of Missouri. (See, Relator's Ex. 9 at p. 012.)

The Curators of the University of Missouri entered into a contract with the city of Columbia whereby the University agreed to provide certain "physician services" to the CBCHD. (Id. at p. 003.). Howenstine's employment has always been exclusively controlled by the University of Missouri. Her salary and all job related benefits were paid exclusively by the University of Missouri. (Id. at pp. 012, 056-58.) Howenstine herself

characterized her status and involvement at the CBCHD as being "subcontracted." (Id. at p. 006.) Unlike those who are actually employed by the CBCHD, Howenstine had no official job description. (Id. at p. 007.). Indeed, Howenstine was simply the physician her employer, the University of Missouri, designated to provide the enumerated "physician services" to the CBCHD.

Continuing the analysis, Howenstine's position, her duties, and whatever authority she held at CBCHD were not created by any Missouri law or statute. Her presence was not mandated by any enactment of any governing body. To the contrary, her duties at the CBCHD are and were the exclusive result of a "bargained-for exchange," in the form of a negotiated private contract between the University of Missouri and the City of Columbia. The physician service which Howenstine was to supply, which most specifically relates to this case, was the maintenance of collaborative practice agreements "… as dictated by expanded practice" with registered nurses employed by the CBCHD. (Id. at p. 003, § II E.) Without question, the process of considering and entering into collaborative practice agreements with registered nurses, for the purpose of expanding Howenstine's medical practice represents a routine duty that licensed physicians regularly perform in both the private and public sector in the state of Missouri. Entry into a collaborative practice arrangement requires a medical license. Certainly, such action cannot be reasonably construed as a delegation of or an exercise of any portion of the governing or "sovereign power" of the state of Missouri, Boone County, or the City of Columbia. Instead, the contractual duties represent nothing more than a negotiated medical assignment given to

Howenstine by her exclusive employer, the University of Missouri. Howenstine holds no office created by statute or law.

Similarly, as required by the test set forth in Kirby, et al. v. Nolte, 164 S.W.2d 1 (Mo. banc 1942), Howenstine's "office" lacks "continuity." Howenstine serves at the pleasure of both the Curators of the University of Missouri and the City of Columbia. Her "office" is therefore subject to the control of both the University and the City of Columbia. The contract from which Howenstine's job and status emanate is for an original term of one year, with four additional one year renewals. (See, Relator's Ex. 9 at p. 003.) Further, the agreement is conditioned upon and made "subject to appropriation of funds for each fiscal year." Finally, both the University of Missouri and the City of Columbia have the right to terminate Howenstine's presence at the clinic and the contract after first giving written notice "sixty (60) days prior to the effective date of termination." Based upon Kirby, et al. v. Nolte, supra, Howenstine's job demonstrates no continuity and is subject to the private control of her two superior authorities, i.e. the University of Missouri and the City of Columbia to whom she answers.

2. Howenstine's actions and failures to act, which are the basis of Plaintiffs' claims, do not constitute an "exercise of the sovereign's power"

As set forth above in State ex rel. Eli Lilly v. Gaertner and Cooper v. Bowers, in order to claim the protection of official immunity, the actions of the official seeking to be shielded must be both "discretionary" and must be "made in the exercise of the sovereign's power [and] go to the essence of governing." State ex rel. Eli Lilly v. Gaertner, at 765.

As outlined in the Statement of Facts, in September of 1996, the state of Missouri adopted a collaborative practice law. Under the provisions of 4 C.S.R. 200-4.200, et seq., a licensed Missouri physician is authorized to expand his/her practice by entering into a "collaborative practice arrangement" with a registered nurse. By virtue of a collaborative practice arrangement, a physician can delegate the ability to perform specified medical acts (herein diagnosis of adverse reactions to tuberculosis medications and decision-making regarding dispensing more tuberculosis medications to the patient) to the nurse. The nurse's power to perform such medical acts derives and flows solely from the collaborating physician, herein Dr. Howenstine.

The regulations promulgated to control collaborative practice in Missouri are not without safeguards. Specifically, 4 C.S.R. 200-4.200(3)(B) provides:

> (B) The collaborating physician shall … ensure that the delegated responsibilities contained in the collaborative practice arrangement are consistent with that level of skill, education, training and competence. … [of the collaborating nurse.]

This regulation thus creates a duty on the part of the physician to delegate only to those registered nurses who are competent to discharge the delegated responsibilities in compliance with applicable standards of care.

In the current case, counsel for Relator argues that an immunity shield should be raised on behalf of Dr. Howenstine because the delegation took place in a public clinic and because Howenstine was given the title "medical director." Under Relator's reasoning, a practicing physician in a public clinic could enter into a collaborative practice arrangement,

delegating authority to perform any medical act to any registered nurse, without regard for the nurses' skill, education, training and competence to do the act, without liability attaching. Such an interpretation would promote laxity where there should be the highest vigilance. Further, permitting delegation without accountability would encourage the erosion of the quality of health care delivered to Missouri residents through public clinics. Such an interpretation can certainly not be construed as consistent with the Missouri Department of Health's statutory mandate to "safeguard the health of the people in the state and all its subdivisions." See, Mo. Rev. Stat. § 192.020. (Appendix to Relator's Brief, Ex. 3, p. A39.)

The question thus becomes, whether entry into a collaborative practice arrangement by a physician practicing in a public clinic, constitutes some form of exercise of sovereign power? In answering the question, it is first apparent that since 1996, collaborative practice arrangements have been used by Missouri physicians practicing in both private and public settings. Can it be said that a licensed Missouri doctor involved in the private practice of medicine that enters into a collaborative practice arrangement with a nurse, who thereby delegates responsibility for tuberculosis care, exercises the sovereign power of the state of Missouri? Obviously not. Does the same action, in the context of a public clinic, somehow transform entry into a collaborative practice arrangement into a government act? Is the same action in a public clinic transformed into an exercise of some "sovereign power?" Obviously not. Analytically, the act of entering into a collaborative practice arrangement, delegating the ability to perform medical actions in the place of the doctor, is the same whether in the context of private or public clinics. Moreover, the act of entering into a

collaborative practice arrangement is premised upon medical decision-making. More specifically, the collaborating physician, by regulation, is charged with the responsibility to investigate and know what the relative skill, education, training, and competence of a prospective collaborating nurse is. These assessments require medical judgment and medical evaluation. They are the kind of evaluations that only a licensed physician is qualified to make. They are the kinds of medical decision-making that occurs each day in the private health care settings throughout the state. Such decisions are not government actions reflecting an exercise of sovereign power.

Relator has advanced curious and specious reasoning regarding why Howenstine should be deemed a "public official" for purposes of official immunity. Relator's logic is that because the Missouri Department of Health has entered into a contract to provide funds to the CBCHD and because Howenstine is the "medical director" of the CBCHD; somehow the CBCHD has assumed the "sovereign functions" of the Missouri Department of Health by delivering tuberculosis services in a clinic open to the public.

First, the contract between the Missouri Department of Health and the CBCHD is set forth in Relator's Ex. 6, pp. 093-102. That contract says nothing about providing tuberculosis control services. What it does say is:

> 14. The relation of the contractor to the department shall be that of an independent contractor. The contractor shall have no authority to bind the department for any obligation or expense not specifically stated in this contract. **The contractor shall have no authority to represent itself as an agent of the department.** (Id. at p. 094.)

Under the terms of the Program Services Contract, there is no delegation of sovereign authority and absolutely no mention of tuberculosis control services. Succinctly, the Program Services Contract provides a fixed amount of money to the CBCHD to undertake numerous unrelated reporting obligations. There is certainly no basis for claiming that the CBCHD has somehow become an extension of the Missouri Department of Health by virtue of such contract.

Similarly, beyond reciting that Howenstine is the "medical director" of the CBCHD, Relator offers no explanation regarding how Howenstine is transformed from a part-time, university physician, practicing medicine, into a "public official." Relator offers no facts or analysis regarding the test enumerated in Kirby, et al. v. Nolte, supra. Moreover, Relator provides no explanation regarding how Howenstine's actions and failures to act by negligently entering into collaborative practice arrangements represents an exercise of the sovereign power of either the state of Missouri, the Missouri Department of Health, Boone County or the City of Columbia.

Relator cites Benjamin v. University Internal Med. Found., 492, S.E.2d 651 (Va. 1997), as authority for the prospect that Howenstine should be granted immunity in this case. It is obvious, from reading the text of the opinion, that it has no application to the facts of this case. In the Benjamin case, a young woman died following treatment for headaches and neck pain at the Medical College of Virginia Hospital. Following the death, the decedent's representative filed suit against Julie Ann Samuels, M.D., the medical director of the University Internal Medicine Foundation ("UIMF"), based on the theory that Dr. Samuels, as medical director, was responsible for the actions of the treating physicians.

Dr. Samuels asserted the defense of sovereign immunity. The trial court and Supreme Court of Virginia ultimately held that Dr. Samuels was acting as an administrator of a state-run public health facility and was therefore entitled to sovereign immunity. Unlike the current case, the Benjamin case did not involve the Missouri Collaborative Practice Act, or a practicing physician's negligent delegation of authority to collaborating nurses to conduct medical acts on her behalf to individual patients. The Benjamin case has no application to the facts at bar.

Relator's final argument on this point is that Howenstine's duty to train and supervise CBCHD nurses is controlled by Kanagawa v. State, 685 S.W.2d 831 (Mo. banc 1985), and other cases which have held that supervision of employees is a discretionary function protected by official immunity. This argument is both disingenuous and a complete misdirection in this case. It ignores the fact that Plaintiffs' claims are not premised upon some non-specific administrative duty to supervise or train. Rather, they are premised upon the specific act of negligently entering into a collaborative practice arrangement delegating medical powers to specific nurses who were not qualified. This case is premised upon the statutory duty to "ensure" the competence of those to whom delegation is made. It is a statutorily prescribed duty, which by its terms, excuses no collaborating doctor. As set forth above, when faced with the prospect of entering into a collaborative practice arrangement with unqualified nurses, in light of Howenstine's regulatory duty to "ensure" that her collaborating nurses have the requisite "skill, education, training and competence" to complete the "delegated responsibilities," Howenstine had two choices. First, she could decline to enter into the collaborative practice arrangement, i.e. not

delegate authority to those who lack training, skill and competence; or she could undertake or see to the training and education of such nurses to assure that appropriate skill sets and competence were gained.

Relator goes on to represent to the Court that Plaintiffs were unable to point to any testimony by heath department employees to support their assertion that Dr. Howenstine had responsibility to train and supervise nurses. Such allegations are simply not true and ignore the sworn testimony of Mary Martin, Public Health Manger of the CBCHD. For example, during Martin's deposition the following questions and responses were elicited:

> Q: … In the summer of 2000 when Mr. Muren was seen at the clinic by Nurse McAffe, Miller, Potter, Davison, at the time he was seen, each of those nurses was an employee of the City of Columbia, correct?
>
> A: Yes.
>
> Q: Supervised by Lisa Lamm, yourself and Dr. Howenstine?
>
> A: Yes.

(See, e.g., Relator's Ex. 9 at p. 024.) Further, Relator's own expert, Dr. Colleen Kivlahan, testified that Dr. Howenstine had responsibility to assure that the nurses she collaborated with had appropriate skills and knowledge. (Id. at p. 033.)

Howenstine was charged with the duty to supervise and train the public health nurses at the CBCHD. Moreover, the specific provisions of 4 C.S.R. 200-4.200(3)(B) required that Howenstine "ensure" that the registered nurses to whom she delegated responsibility had the requisite skill, education, training and competence to complete the delegated tasks.

Under the facts at bar, Howenstine has failed to demonstrate that she is a public official. Further, and most importantly, she has failed to demonstrate that the acts and failures to act which form the basis of Plaintiffs' claims against her – i.e. negligent entry into collaborative practice arrangements – represent an exercise of the sovereign power of any recognized governing body. The Honorable Ellen Roper correctly assessed that, at a minimum, there were multiple controverted issues of material fact which prevented entry of summary judgment on the issue of "official immunity." This Court's preliminary Writ of Prohibition should be vacated and this action should be returned to Judge Roper for trial on the merits.

B. Relator has no immunity from liability under the Public Duty Doctrine because (1) Howenstine is not a public official entitled to assert public duty immunity and (2) Missouri law and the Collaborative Practice Act establish a duty, both in private and public health clinics, which runs to persons, including Paul Muren, who receive negligent medical care from nurses empowered to act in Howenstine's place by her collaborative practice arrangement

The Missouri Public Duty Doctrine

In Missouri, the public duty doctrine shields a public official from tort liability to a person injured by his/her negligence if the public official is involved in the performance of his/her public duty. See, e.g. Brown v. Tate, 888 S.W.2d 413 (Mo. App. W.D. 1994). The rationale behind the doctrine quite simply is that the tort-feasor is discharging a duty owed only to the general public and not to the person injured. Id. at 416. Once it has been determined that the tort-feasor is in fact a public official, the focus of the inquiry regarding the public duty doctrine becomes the nature of the duty created, whether it is a duty to the general public or to a class of particular individuals that includes the plaintiff. See, e.g. Voyle v. City of Liberty, Mo., 833 F.Supp. 1436, 1441 (W.D. Mo. 1993).

Finally, the Missouri cases that have utilized the public duty doctrine have involved situations where there clearly was no duty owed to a particular individual. For example, in Lawhon v. City of Smithville, 715 S.W.2d 300, 302 (Mo. App. 1986), the court held that the creation of a municipal fire department is for the benefit of the public, and the duty is owed to the entire community. Similarly, the enforcement of a municipality's ordinances by the

police is a public duty and no liability arises from the breach of that public duty. See, e.g. Christine H. v. Derby Liquor Store, 703 S.W.2d 87, 89 (Mo. App. 1985). In Heins Implement v. Hwy. & Transp. Com'n., 859 S.W.2d 681 (Mo. banc 1993), this court held that the duty of the Missouri Highway Transportation Commission and its design engineer to properly design and construct highways runs to the public at large.

In Berger v. City of University City, 676 S.W.2d 39 (Mo. App. 1984), the Missouri Court of Appeals, Eastern District, considered claims asserted against a city manager, a police chief and a police major who were in charge at the scene of a fire and failed to enforce city ordinances to provide police protection to firemen from neighboring municipalities so they could extinguish a blaze. Apparently, the local firefighters were on strike and threatened firemen from surrounding municipalities who arrived to fight the fire. The Court of Appeals held that the enforcement of the law and keeping of the peace are duties which a municipality and its employees owed to the general public. The breach of that public duty gave no right of action to a private citizen. Berger v. City of University City at 41.

1. Howenstine is not a public official and the "Public Duty" Doctrine has no application to her acts

First, as set forth above in the "official immunity" analysis, Howenstine is not a "public official." Without reiterating the entire analysis, it is apparent that her status in this case is that of a part time university doctor; whose employer has entered into a private contract to furnish "physician services" to a public clinic; whose employer has assigned Howenstine to provide those physician services; that as directed by her employer,

Howenstine subsequently provided physician services, including primary care medical services, oversight of advance practice nurses, oversight of family medicine residents and collaborative practice arrangements with registered nurses at the clinic; and that the physician services Howenstine provided were all routine medical actions of a practicing licensed physician, regardless of the setting.

Further, it is undisputed that Howenstine is not an elected or appointed official; that her "position" was not created by Missouri law or statute; that there is no continuity to her "office" as it is exclusively subject to the control of both the University and the City of Columbia; that she is not an employee of the state of Missouri, the Missouri Department of Health, Boone County, or the City of Columbia; that she is not an employee of the CBCHD, the entity through which she claims her immunity status; and that her actions, which have given rise to the Muren lawsuit (collaborating with and delegating authority to nurses to see tuberculosis patients in her place, without ensuring they possess the requisite skill, education, training and competence) do not involve exercise of "sovereign power."

Based on the test enumerated in Scobee v. Meriweather, supra, and Kirby, et al. v. Nolte, supra, Howenstine is not a "public official." As a result, she enjoys no protection from the "Public Duty" doctrine for her negligent acts.

2. Missouri law and the Collaborative Practice Act establish a duty, both in private and public health clinics, which runs to persons, including Paul Muren, who receive negligent medical care from nurses empowered to act in Howenstine's place by her collaborative practice arrangement

Counsel for Relator would have the Court believe that the collaborative practice regulations, cited above, and the duty to "ensure that the delegated responsibilities contained in the collaborative practice arrangement are consistent with the level of skill, education, training and competence" of those she delegates to, creates no duty to Paul Muren.

However, counsel for Relator has failed to cite any authority in support of the argument that the duty codified by 4 C.S.R. 200-4.200(3)(B) is a public duty as opposed to one that runs to those who will receive medical treatment as a result of the delegation by the physician. It is undisputed that by virtue of such delegation, registered nurses at the CBCHD performed medical services and provided medical care traditionally performed by family practice physicians, such as Dr. Howenstine. But for Howenstine's grant and delegation of authority, these nurses never would have been placed in a position to cause harm by their negligent "medical acts" (continuing to dispense INH to patients who experienced and demonstrated symptoms of an adverse reaction to the drug).

Missouri courts have recognized and held that ". . . rarely, if ever, will the public duty doctrine provide a shield from liability where the official immunity doctrine would not. The two doctrines merge; they produce the same result." Brown v. Tate, 888 S.W.2d 413, 416 (Mo. App. W.D. 1994).

In Brown v. Tate, the parents of Alfonso Brown, a minor, filed suit for wrongful death. Brown had collided with police officer Kathryn Larson in an intersection under circumstances where Larson was driving too fast and failed to maintain a careful lookout. There was no emergency warranting high speed. Officer Larson moved to dismiss based upon the public duty doctrine, among other things. The Missouri Court of Appeals,

Western District, held that the public duty doctrine had no application. The court reasoned that "the officer's duty to operate a motor vehicle with the highest degree of care, and to obey traffic rules and regulations, in a non-emergency situation, cannot be said to be a duty owed only to the public at large; it is a duty owed to all who might be injured by negligent operation of the automobile." Id. at 416.

In Green v. Dennison, 738 S.W.2d 861, 866 (Mo. banc 1987), this court stated "we do not disagree with the proposition that public officials may be required to exercise care to avoid injury to particular individuals, when the injury is reasonably foreseeable and is not an integral part of the officer's action in the line of discretionary duty." Green v. Dennison, at 866. In that case, this court cited State ex rel. Eli Lilly & Co. v. Gaertner, 619 S.W.2d 761 (Mo. App. 1981), with approval, for the proposition that in Missouri, "… a physician in public employment owes the normal physician-patient duties to those he examines and treats." Green v. Dennison, at 866. The same rationale must be extended to patients who are examined and treated by a doctor's collaborating nurse, who sees the patient in the doctor's stead, as a result of a delegation of authority under a collaborative practice arrangement.

The Collaborative Practice Act itself provides for individual physician liability in connection with entry into collaborative practice without regard for whether the injury occurs in a private or public clinical setting. In addressing the "methods of treatment delegated" 4 C.S.R. 200-4.200(3)(I) states:

1. The physician retains the responsibility for the appropriate administering, dispensing, prescribing and control of drugs utilized pursuant to a collaborative practice arrangement . . .

Further, as set forth above, when the Missouri Department of Health implemented the Collaborative Practice Act, pursuant to its rule making authority in 1996, it expressly addressed the issue of the physician's liability for collaborative practice arrangements in the comments contained within the Missouri register. There, the following statements appear:

> COMMENT: Within the Methods of Treatment section, one letter of comment addressed paragraph (3)(I)1. with the concern that no physician will want to enter into a collaborative practice arrangement that includes the specified provision of responsibility and accountability related to drugs.
>
> **RESPONSE: The boards identified that the decision to enter into a collaborative practice arrangement is voluntary and, <u>whether stated or not, delegated medical acts carry with them physician responsibility to provide suitable oversight to validate having made appropriate delegative decisions</u>.** *See*, <u>Order of Rulemaking</u>, Volume 21, Mo. Register, No. 15, August 1, 1996, p. 1794. (emphasis supplied) (Relator's Ex. 15 at p. 023.)

Again, no exception was articulated for doctors who enter into collaborative practice arrangements in public clinics or regarding the delivery of tuberculosis care. The clear inference of both 4 C.S.R. 200-4.200(3)(I) and the comments contained in the Missouri Register are that the physician will retain responsibility and liability for negligence in

connection with the "dispensing" and "control" of drugs utilized pursuant to collaborative practice arrangements. It is at once apparent that the intended responsibility and liability would run to those who are injured by virtue of negligence in connection with improper dispensing and/or control of drugs such as occurred in this case. In the current case, Paul Muren was injured by nurses who insisted that he continue taking and negligently dispensed the drug INH to him after he began to demonstrate symptoms of an adverse reaction to the drug. The above-referenced regulations and the legislative history which preceded them confirm the existence of a legal duty and retained liability by the physician for breach of that duty. Specifically, the crafters of the rule acknowledge that the medical acts delegated to registered nurses required oversight and carried "physician responsibility" and "accountability."

In this case, Howenstine delegated the "methods of treatment" regarding TB control to registered nurses at CBCHD. As a part of the delegation, she placed the nurses in a position, in her stead, to make a medical diagnosis, i.e., whether or not symptoms Paul Muren reported and, which were documented, were caused or related to an adverse reaction to the drug INH and resulting underlying liver disease process. The nurses were negligent in failing to conduct liver function testing as required by protocols which were in place at CBCHD. Quite simply, the nurses lacked the training, education, skill and competence to understand and know that persons who demonstrate symptoms of liver toxicity must have blood drawn to determine whether or not liver enzymes born in the blood are elevated, reflecting liver injury. The nurses failed to accurately diagnose Paul's advancing liver injury. Moreover, despite evidence of his progressing injury, they continued to negligently

dispense the toxic drug to him in violation of the standard of care. They failed to comprehend the gravamen of the reported symptoms and the medical responsibility Howenstine had delegated to them. That injury would result to the individuals being treated by the nurses, (in Howenstine's place by virtue of her delegation) goes without saying.

The test regarding whether the duty owed is a public duty, enunciated in Green v. Dennison, 738 S.W.2d 861, provides that a duty runs to individuals (therefore not a public duty) when "… the injury is reasonably foreseeable and is not an integral part of the officer's action in the line of discretionary duty." Green v. Dennison, at 866. "Discretionary duty," as utilized by the Green court, and as set forth above, refers to those situations where the official is "exercising the sovereign's power" – the "essence of government." Here, the foreseeable injury occurred not in the exercise of the essence of sovereign power by Howenstine, but rather it occurred in the delivery of medical services and medical care as a result of Howenstine empowering nurses to medically act in her stead. Clearly, as in all other cases in the state of Missouri, a physician in public employment owes the normal physician-patient duties to those she examines and treats and to those whom are examined and treated by her collaborating nurses by virtue of his/her delegation of authority to nurses to act in her place through collaborative practice arrangements.

Relator Howenstine enjoys no immunity under the public duty doctrine. The Muren claims against her have nothing to do with administrative actions such as her adoption of protocols for TB control. Rather, they stem directly from Howenstine's mandated obligations under the Missouri Collaborative Practice Act and the liability which attaches

and flows from her duty to ensure that those who receive her delegation possess the requisite "skill, education, training and competence."

As with the claim of official immunity, Dr. Howenstine's Petition for a Writ of Prohibition based on the "public duty" doctrine is completely misguided. First, there is no question but that the entitlement to prohibition is not demonstrated on the face of the underlying pleadings in this cause. Certainly, resort must be made to matters beyond the face of the pleadings. Moreover, and even more fundamental, there remain contested issues of fact regarding Howenstine's status as a "public official." Because she is not a "public official," she has no right to assert the "public duty" defense. Further, even if she were a public official, the actions which Howenstine undertook, which form the basis of Plaintiffs' claims against her, are not actions undertaken in the exercise of the sovereign power of the state of Missouri, Boone County, or the City of Columbia. Rather, they are medical actions that require a medical license and represent medical decision-making in its purest form. The negligent delegation of authority to registered nurses who lack the requisite skill, education, training and competence to act in the place of doctors must result in physician responsibility. This Court's preliminary Writ of Prohibition should be vacated and this action should be returned to Judge Roper for trial on the merits.

Dated this 23rd day of September, 2004.

Respectfully Submitted,

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RULE 84.06(C) CERTIFICATION

The undersigned certifies that the foregoing brief complies with the limitations of Rule 84.06(b), that the brief contains 10,877 words, including footnotes, and that two genuine copies of the brief and a floppy disk containing the same, were served via First Class United States Mail, postage prepaid, this 23rd day of September, 2004, to:

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RULE 84.06(g) CERTIFICATION

The undersigned certifies that each floppy disk filed with the Court and/or served on the parties pursuant to Rule 84.06(g) were scanned for viruses and that each was virus-free.